

10CFR50.73

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U.S. Nuclear Regulatory Commission ATTN: Document Control Desk Washington DC 20555-001

> LER 311/2010-001 Salem Nuclear Generating Station Unit 2 Facility Operating License No. DPR-75 NRC Docket No. 50-311

Subject:

Manual Reactor Trip Due to Degraded Condenser Heat Removal

This Licensee Event Report, "Manual Reactor Trip Due to Degraded Condenser Heat Removal" is being submitted pursuant to the requirements of the Code of Federal Regulations 10CFR50.73(a)(2)(iv)(A).

The attached LER contains no commitments. Should you have any questions or comments regarding this submittal, please contact Mr. E. H. Villar at 856-339-5456.

Sincerely,

Carl J. Fricker

Site Vice President - Salem

Attachments (1)

IENER

CC

Mr. S. Collins, Administrator - Region I

Mr. R. Ennis, Licensing Project Manager - Salem USNRC Senior Resident Inspector - Salem (X24)

Mr. P. Mulligan, Manager IV

Mr. H. Berrick, Salem Commitment Tracking Coordinator

Mr. L. Marabella, Corporate Commitment Tracking Coordinator

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LICENSEE EVENT REPORT (LER)

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Salem Generating Station Unit 2	05000311	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
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NARRATIVE

PLANT AND SYSTEM IDENTIFICATION

Westinghouse – Pressurized Water Reactor (PWR/4)

Reactor Protection System (JC/-) Circulating Water System (KE/ -)

* Energy Industry Identification System {EIIS} codes and component function identifier codes appear as {SS/CCC}

IDENTIFICATION OF OCCURRENCE

Event Date: January 3, 2010

Discovery Date: January 3, 2010

CONDITIONS PRIOR TO OCCURRENCE

Salem Unit 2 was in Operational Mode 1.

No structures, systems or components were inoperable at the time of the discovery that contributed to the event.

DESCRIPTION OF OCCURRENCE

On January 3 starting at approximately 0600 hours, with Salem Unit 2 at 100% power, control room operators received multiple circulating water {KE/}(CW) traveling water screen {KE/}(SCN) high differential pressure alarms. For the next two hours control room operators responded in accordance with operating and abnormal operating procedures (AOPs) to address heavy ice accumulation on the traveling water screens. Environmental conditions at the time of the event included: at 0600 air temperature was 19°F, wind speed approximately 22 mph, river temperature at 31.8 °F; at 0830 air temperature was 20°F, wind speed approximately 24 mph, and river temperature was 31.1°F.

The following is a brief time line (all times are approximate) leading to the initiation of the manual reactor trip:

0712 Licensed operating personnel initiated a stop on 23B circulating water pump (circulator) due to a TWS differential pressure of five (5) feet, while the 23B circulator was cycling out of service it emergency tripped on a high TWS differential pressure of eight (8) feet and rising.

0723 23B circulator is placed in service in accordance with operating procedures.

0740 23B circulator emergency tripped due to high TWS differential pressure.

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NARRATIVE

DESCRIPTION OF OCCURRENCE (cont'd)

0745 21B circulator emergency tripped due to high TWS differential pressure.

0747 Commenced reducing main turbine load at 1% per minute to 80% power in accordance with abnormal operating procedures.

0748 23A circulator emergency tripped due to high TWS differential pressure.

0754 21B circulator placed in service and then emergency tripped due to high TWS differential pressure.

0803 21A circulator emergency tripped due to high TWS differential pressure.

0804 Unit 2 reactor is manually tripped from approximately 80% due to having only two circulators (22A and 22B) in service. Control room operating personnel transitioned to Emergency Operating Procedure Trip 1. As expected, the Auxiliary Feedwater Pumps started automatically to feed the steam generators.

0837 Unit 2 is stabilized in Mode 3 in accordance with plant operating procedures.

The unit was returned to service on January 4, 2010, at 1831 after ice was cleared from the screens, condenser water boxes were cleaned and demonstrated to operate properly.

This report is being made in accordance with 10CFR50.73(a)(2)(iv)(A), "any event or condition that resulted in manual or automatic actuation of any of the systems listed in paragraph (a)(2)(iv)(B)...."

CAUSE OF OCCURRENCE

The cause of the manual reactor trip is attributed to high amounts of river ice and resultant accumulation of ice on the CW traveling water screens. The heavy ice loading caused the high TWS differential pressure. A TWS differential pressure of ten (10) feet causes a circulating water pump trip.

PREVIOUS OCCURRENCES

A review of LERs at Salem Station dating back to 2003 identified two other occasions of a reactor trip due to unusual harsh environmental conditions. LER 311/2003-001 "Manual Reactor Trip Due to Degradation of Condenser Heat Removal" and LER 272/2007-002 "Manual Reactor Trips Due to Degraded Condenser Heat Removal" were caused by excessive grassing. The corrective actions associated with these events were intended to improve the reliability of the CW system in responding to excessive river grass; and therefore would not have been expected to prevent the occurrence of this ice related event.

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NARRATIVE

SAFETY CONSEQUENCES AND IMPLICATIONS

There was no actual safety consequence associated with this event. Operators appropriately responded to the degraded CW system (loss of circulating water pumps) and the potential loss of normal heat sink (condenser) by manually tripping the reactor in accordance with plant procedures. Plant response to the manual reactor trip was normal. All safety systems operated as required, including the service water system which also takes suction from the river.

A review of this event determined that a Safety System Functional Failure (SSFF) as defined in NEI 99-02, Regulatory Assessment Performance Indicator Guidelines, did not occur. The event did not result in a condition that alone could have prevented the fulfillment of a safety function of a system needed to remove residual heat.

CORRECTIVE ACTIONS

- 1. Circulating water traveling water screens and condenser water boxes were cleaned, inspected and returned to normal service.
- 2. A root cause evaluation was initiated to identify other potential causes and corrective actions to improve response to severe weather conditions.
- 3. This evaluation and any identified improvements will be tracked in PSEG's corrective action program.

COMMITMENTS

No commitments are made in this LFR.